

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED: 7007 3020 0001 4038 8362

March 15, 2012

Brent Bryson, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

RE: Intermountain Hospital, Provider #134002

Dear Mr. Bryson:

This is to advise you of the findings of the Medicare/Licensure survey at Intermountain Hospital, which was concluded on February 29, 2012.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey. Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable

Brent Bryson, Administrator
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Page 2 of 2

- plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **March 28, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

*Rebecca Lara RN, BA, HFS
for*

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm
Enclosures



March 26, 2012

Department of Health and Welfare
Bureau of Facility Standards
Sylvia Creswell, Supervisor
Non-long Term Care

Teresa Hamblin, RN, BA, HFS
Health Facility Surveyor
Non-long Term Care

HAND DELIVERED

Dear Sylvia and Teresa,

Enclosed please find our Plan of Correction for Treatment Planning (BB 175) and Record Content(BB283) .
The Bureau of Facility Standard form and Plan of Correction response form is attached and identifies the
standard, deficiency, action plan, educational program and monitoring plan for the deficiency.

Upon review of our Plan of Correction, if you have any questions, don't hesitate to contact me.

Sincerely,

B. Bryson / *[Signature]*
Brent Bryson
CEO

Attachments: State Form

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MAR 26 2012
FACILITY STANDARDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/29/2012
NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704	
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A 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation of your hospital. The investigation identified immediate jeopardy to patients' health and safety. The surveyors conducting the survey were:</p> <p>Teresa Hamblin, RN, MS, HFS Gary Guiles, RN, HFS Rebecca Lara, RN, BA, HFS</p> <p>Acronyms and terms used in this report include:</p> <p>AED = Automated External Defibrillator asystole = the absence of a heartbeat CNO = Chief Nursing Officer CPR = cardiopulmonary resuscitation H&P = History and Physical Examination LPN = Licensed Practical Nurse MTP = "MASTER TREATMENT PLAN." NIH = National Institutes of Health Obs = Observation Room PI = Performance Improvement pt - patient PT = Psychiatric Technician RN = Registered Nurse UHS = Universal Healthcare Systems</p>	A 000	<p>By submitting this Plan of Correction, the Facility does not admit that it violated the regulations. The Facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency.</p> <p>This plan of correction (A115) was submitted to the surveyors reviewed and accepted on 2/24/12 to lift IJ.</p> <p>Patient Rights A115 482.13: Intermountain Hospital now ensures that the patients' rights are protected and promoted. The following immediate response by Intermountain Hospital addressed the Immediate Jeopardy and fully abated the cited patient care concerns:</p> <ul style="list-style-type: none"> • A Code Blue Flow Sheet was drafted to address staff response to Code Blue events including the requirements to perform CPR. Completed Date: February 24, 2012 • A Definitions page with staff acknowledgement was included to document staff review, understanding and required responsibilities during CPR. Completed Date: February 24, 2012 • Intermountain Hospital provided immediate staff education related to the flow sheet and for all staff scheduled from 1500 February 24, 2012 through 0800 February 27, 2012. • Intermountain Hospital provided education for all direct care staff. Initiated on February 24, 2012 for all staff working from 2/24/12 through 2/27/12. A list of all hospital staff was generated including both direct and indirect staff and physicians/mid-levels. 	2/24/12
A 115	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of medical records, hospital policies, meeting minutes, and NIH documents, it was determined the hospital failed to protect and promote patient rights. This resulted in patients being placed in</p>	A 115		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

[Signature]

ceo

3-21-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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MAR 28 2012

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A 115	Continued From page 1 immediate jeopardy from the potential for suffering serious harm, impairment, or death from an inefficient CPR response. Findings include: Refer to A 144 as it relates to the hospital's failure to ensure patients who suffered cardiopulmonary arrest received care in a safe setting. Note: On Friday 2/24/12 at 12:00 noon, the CEO, CNO, and Director of Performance Improvement/Risk Management were notified in person of the immediate jeopardy related to the hospital's failure to ensure an efficient response was provided to patients who suffered cardiopulmonary arrest. A plan of correction was received, reviewed, and accepted on 2/24/12 at 4:15 PM. The plan revised the Code Blue-CPR procedure so the staff member finding a victim who is in arrest will immediately notify staff and begin CPR. The procedure clarified the role of staff in the code blue and assigned specific staff to take charge of the CPR. The procedure also prompted staff to bring emergency equipment to the site. The hospital immediately began educating direct care staff on the new procedure and planned to in-service staff as they came on duty until all staff had been educated. Administrative and direct care staff were interviewed on Monday, 2/27/12 to ensure staff had been trained on the current procedure. The immediate jeopardy was abated and the CEO was notified in person at that time.	A 115	This list was used to ensure all staff understood their responsibilities to provide immediate response to medical emergencies including cardiac arrest and code blue. Staff completed their documentation of education through March 21, 2012. 100% of all staff was achieved or documentation completed for those on leave/FMLA. Completed on February 24, 2012. • Intermountain Hospital provided education for staff not involved in direct patient care. Initiated on February 24, 2012 and Completed on March 28, 2012. Monitoring: The CNO tracked and documented the completion of the education to ensure that all staff received the required education. This information was presented and reviewed at the Quality Council Meeting on March 22, 2012 and presented at the the MEC meeting on March 27, 2012. The Board of Governors will review the data during the 2012 First Quarter meeting in April 2012. Audits will continue for 3 months and will decrease to periodic checking when compliance is achieved and sustained.	3/27/12	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING	A 144			

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A 144	<p>Continued From page 2</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, hospital policies, meeting minutes, and NIH documents, it was determined the hospital failed to ensure efficient systems had been developed, and staff sufficiently trained, to provide a rapid and consistent response to patients who suffered cardiopulmonary arrest. This negatively impacted the care of 1 of 1 patient (Patient #3) who experienced cardiopulmonary arrest and had the potential to negatively impact all patients who experienced medical emergencies at the hospital. These failures limited the ability of the hospital to respond to medical emergencies and placed patients in immediate jeopardy of serious harm, impairment, or death. Findings include:</p> <p>Patient #3's medical record documented a 47 year old male who was admitted to the hospital on 9/17/11. He died on 9/24/11. His diagnoses included schizoaffective disorder, post-traumatic stress disorder, alcohol abuse, hypertension, possible pulmonary embolism, a fractured right arm, post-traumatic amputation of left leg below the knee, and sores on his stump. He was admitted for suicidal ideation and alcohol detoxification. The "DISCHARGE SUMMARY" by the attending physician, dated 10/07/11, stated "At 6:45 AM [on 9/24/11] he was found unresponsive and CPR was initiated. He was not breathing and had no response. They continued CPR for a while with no response and it was felt that the patient had passed away sometime between 6:15 and 6:45 AM."</p>	A 144	<p>Patient Rights: Care in Safe Setting A144 482.13(c)(2) :</p> <p>The Clinical Administrative staff (CEO, CNO, Nursing Supervisors and PI Director) met on 2/24/12 to review the response process to provide a rapid and consistent response to patient who suffered cardiopulmonary arrest.</p> <p>The Code Blue Policy and Procedure (1000.13 –Attachment A) and Medical Emergency response of hospital staff was reviewed and evaluated on 2/24/12 for effectiveness and prompt response. As a result of this review process, the following changes were implemented immediately.</p> <ul style="list-style-type: none"> • The CNO and clinical administrative staff reviewed and revised the Code Blue Policy. The Code Blue Policy now dictates the process for announcing a Code Blue. The policy includes the staff's responsibilities in the event of a cardiopulmonary arrest and the appropriate response by all CPR trained staff. The revised policy also indicates the responsibilities of clinical/non-clinical staff not trained in CPR and their role in assisting during a cardiopulmonary arrest. The revised policy now provides direction for all staff (see below) on how to respond to other medical emergencies that may occur when there is a change in the patient's condition. <ul style="list-style-type: none"> o Direct care staff o Non-clinical staff 		<p>2/24/12</p> <p>2/24/12</p>

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A 144	Continued From page 3 On 2/23/12 beginning at 7:45 AM, a video of the events on 9/24/11, from 6:00 AM through 7:27 AM, was viewed with RN C, who was the RN Charge Nurse who was on duty at the time of the event. There was no sound track to the video. The time on the video time stamp began at 00:00 (minutes, seconds) which corresponded to 6:00:00 AM. The timeline was as follows: 43:02 PT F entered Patient #3's room. 43:36 PT F left the room and summoned RN C. RN C entered the room at 43:58 with PT F. 44:10 RN C left the room and returned to the nursing station. 44:45 PT F left the room, leaving Patient #3 unattended. He got his clipboard and resumed his 15 minute bed checks. 46:15 RN C re-entered the room. 46:51 RN C left the room and looked around the hallway. At this point, staff from outside entered the unit and went to Patient #3's room. 46:59 RN C entered Patient #3's room with other staff, including RN A, immediately following him. 47:11 The House Supervisor, an RN, came on the unit and entered Patient #3's room. 47:24 The House Supervisor left the room and walked to the nursing station. 49:31 The House Supervisor re-entered Patient #3's room. She came back out and went to an examination room next to the nursing station. She retrieved the emergency cart, which included oxygen, airways, a bag valve mask, and suction equipment, and re-entered Patient #3's room at 50:48. 54:06 Fire department personnel arrived and entered Patient #3's room. At that point, they assumed care of Patient #3.	A 144	o Medical Staff – Physicians, Nurse Practitioners and Physician Assistants. • A Code Blue flow sheet (Attachment – B) was implemented to document actions taken during a Code Blue. This form was implemented on Feb 24, 2012. • Retraining on the revised Code Blue Policy was initially completed per A 115 tag and fully completed on March 28, 2012. • A Definitions page (Attachment – B) with staff acknowledgment was incorporated after the training indicating their understanding and required responsibilities during CPR. This form was implemented on Feb 24, 2012. • The CNO, Nursing managers and nursing supervisors provided immediate training and face to face staff education on the revised Code blue policy and proper completion of forms to all nursing staff. Training was completed on March 28, 2012. • All code blue events are now monitored and audited by the Risk Manager and the CNO or designee. • Video monitoring (if available) of the code blue event is reviewed and findings used to identify opportunities for improvement. • The revised Code Blue policy and Medical Emergency response were presented to the MEC (March 27, 2012) and an ad-hoc Board of Governors meeting March 28, 2012. • Code Blue drills was re-established to monitor and evaluate the effectiveness of staff	2/24/12 3/28/12 2/24/12 ongoing 3/27/12 3/30/12	

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A 144	<p>Continued From page 4</p> <p>59:56 Emergency medical personnel and hospital nursing staff exited the room indicating the resuscitation efforts were over.</p> <p>RN A, who assisted RN C with the resuscitation efforts, documented on the nursing flow sheet at 7:02 AM on 9/24/11 "Paramedics pronounced patient dead. CPR stopped."</p> <p>The time hospital staff called 911 could not be ascertained by the video. However, the "CODE BLUE CLINICAL DOCUMENTATION FORM" for Patient #3 stated 911 was called 4 minutes after he was found unresponsive.</p> <p>PT F, who found Patient #3 on the morning of 9/24/11, was interviewed on 2/23/12 beginning at 3:50 PM. He stated 3 people were on shift when the event occurred, an RN, an LPN, and himself. He said he had checked Patient #3 at 6:30 AM (the video showed this occurring at 6:31 AM) and Patient #3 was breathing at that time. PT F stated he tried to wake Patient #3 at 6:43 AM, to see if he wanted to go on a smoke-break, but Patient #3 did not respond and was not breathing. PT F stated he went to the nursing station and asked the RN C to assess Patient #3 and start CPR. PT F said he told the LPN to call 911. PT F said he then tended to the rest of the patients on the unit.</p> <p>RN C, the Charge Nurse who was on duty at the time of Patient 3's death, watched the video on 2/23/12 beginning at 7:45 AM. He confirmed the times of the events. During a clarifying interview on 2/24/12 beginning at 7:50 AM, RN C stated he did not begin CPR until a second nurse, RN A, arrived at 46:59. RN C stated he and RN A</p>	A 144	<p>response. Code Blue drills will occur at least (1) per shift per month starting March 30, 2012.</p> <p>Monitoring: The CNO and/or designee will monitor 100% of Code Blue events and Code blue drills for appropriate documentation and actions taken by nursing staff. All deficiencies related to the response of a Code Blue will be addressed immediately for compliance by the CNO. The results of this monitoring will be submitted to Quality Council and MEC monthly and to the Board of Governors quarterly. Audits will continue for 3 months and will decrease to periodic checking when compliance is achieved and sustained.</p>	3/30/12	

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A 144	<p>Continued From page 5</p> <p>transferred Patient #3 from the bed to the floor and initiated CPR. RN C stated CPR had not been started prior to this time. Including 5 seconds to transfer the patient, CPR was not started for at least 3 minutes and 28 seconds from the time PT F discovered Patient #3. He stated RN A performed artificial respiration. RN C confirmed oxygen, airways, a bag valve mask, and suction equipment were not available to staff performing CPR until 50:48, at least 7 minutes and 12 seconds from the time PT F discovered Patient #3.</p> <p>The LPN who was on shift when Patient #3 arrested, was interviewed on 2/24/12 beginning at 7:35 AM. She stated PT F came to the desk and she heard him say something about 911. She stated it really did not register because there were patients milling around the nurse's station. The LPN stated RN C went to assess Patient #3 and then returned to the desk. She said RN C told her Patient #3 was not responsive and had no pulse and to call 911. The LPN stated she went to the back room to call 911 so she did not have to make the call in front of the patients. She stated she then announced "Code Blue" (the code for a medical emergency) over the hospital's public address system. She stated otherwise, she was not really involved in resuscitation efforts.</p> <p>Delays in resuscitation efforts for Patient #3 occurred, including 3 minutes and 28 seconds to initiate CPR, 7 minutes and 12 seconds to transport critical equipment to the scene, and 4 minutes to call 911.</p> <p>2. Written staff accounts of efforts to resuscitate</p>	A 144			

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A 144	<p>Continued From page 6</p> <p>Patient #3 on 9/24/11 were gathered and documented by the hospital. The accounts stated what various staff remembered after the event. However, an analysis of the information was not documented. No conclusions were documented.</p> <p>Patient #3's "CODE BLUE CLINICAL DOCUMENTATION FORM," dated 9/24/11, was included in documents that were reviewed. The form stated:</p> <p>"6:45 pt found unresponsive in bed. 6:49 911 called. 6:47 CPR started-AED advised no shock. 6:55 Paramedics arrived. CPR continued. 7:00 Heart monitored-asystole. 7:02 Paramedics pronounced dead. CPR stopped. 7:20 Coroner arrived. 7:25 Police Arrived."</p> <p>The times for the Code Blue were not accurate. The hospital had saved video of the event and a comparison of the times with the video did not match. CPR was not started 2 minutes after the patient was found unresponsive, as noted above.</p> <p>The hospital had a safety committee. "UHS Patient Safety Council Report" minutes for 10/27/11 and 11/21/11, the first 2 meetings following the attempted resuscitation of Patient #3 did not mention the resuscitation efforts. The minutes did state the CNO was "reformatting the code blue forms and will create an emergency cart for New Start [a chemical dependency unit]." The final committee meeting minutes of 2011, dated 12/14/11, also did not mention the resuscitation efforts.</p>	A 144			

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NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
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A 144	<p>Continued From page 7</p> <p>The Policy "Code Blue," revised 10/2003, stated following an actual code or a drill, a "Code Blue/AED PI Tool" would be completed. The Director of Performance Improvement/Risk Management was interviewed on 2/27/12 beginning at 9:50 AM. She confirmed an evaluation of the efforts to resuscitate Patient #3 had not been done. She stated she had reviewed the video of the Code Blue but she had not identified problems. She stated a "Code Blue/AED PI Tool" did not exist. She stated the medical care and cause of death had been investigated regarding Patient #3 but she said CPR efforts had not been evaluated. She stated the discrepancies between the video and the "CODE BLUE CLINICAL DOCUMENTATION FORM" had not been identified.</p> <p>The hospital did not analyze the resuscitation efforts for Patient #3 in order to improve processes and staff performance.</p> <p>3. The Policy "Code Blue," revised 10/2003, stated "A facility Clinical Staff Member, trained in CPR, will implement the Code Blue in the event of cardiac or respiratory arrest." The policy stated the CPR trained staff member would "...assess the patient for the absence of ventilation and/or circulation. 2. Staff member will announce Code Blue, and give precise location over facility paging system. 3. Staff member trained in CPR will begin CPR..." The policy stated the Director of Clinical Services would conduct a "Code Blue Drill" on a quarterly basis "...as a training and educational opportunity for staff."</p> <p>The "Code Blue" policy was not clear. The "Code</p>	A 144			

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A 144	<p>Continued From page 8</p> <p>Blue" policy did not address how staff should announce the code over the paging system or whether they should leave the patient to do so, since as a safety precaution patient rooms did not have telephones. The "Code Blue" policy did not specify roles for various staff members, such as the LPN and the PT. The policy did not state who was responsible to bring emergency equipment to the scene.</p> <p>The CNO was interviewed on 2/24/12 beginning at 9:10 AM. He stated in a situation where the patient was in cardiopulmonary arrest, the PT should go to the nursing station to get the RN. He stated the PT should not yell to the nurse because it would panic the other patients. He stated no specific staff members were designated to get the emergency cart and bring it to the scene. The CNO stated the staff who discovered a patient in arrest should start CPR. He stated hospital staff were instructed to announce "Code Blue" for all medical emergencies including seizures because they wanted all RNs on duty to respond. He stated no "Code Blue" drills had been held in the past year.</p> <p>The policy to do quarterly code blue drills was not implemented. The "Code Blue" policy did not provide sufficient direction to staff in the event a person required cardiopulmonary resuscitation. It did not address how to respond to other medical emergencies staff were expected to respond to when "Code Blue" was announced overhead.</p> <p>4. Nursing staff were interviewed regarding their understanding of the CPR procedure. These included:</p>	A 144			

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A 144	<p>Continued From page 9</p> <p>a. PT F, who found Patient #3 on the morning of 9/24/11, was interviewed on 2/23/12 beginning at 3:50 PM. After determining that Patient #3 was not breathing, PT F said he went to the nursing station to get RN C. He did not start CPR. He said he did not call out for help because he did not want to disturb the other patients. When he and RN C re-entered the room, they still did not start CPR. PT F left Patient #3 without performing CPR to attend to other patients.</p> <p>When asked if he would do anything different if a similar situation arose, PT F stated he would take the same actions. He stated administrative staff came to the conclusion that the CPR participants "did pretty well considering the circumstances."</p> <p>b. RN C, the Charge Nurse who participated in the CPR, was interviewed on 2/23/12 beginning at 7:45 AM. He stated the Director of Performance Improvement/Risk Management asked him about the CPR following the events. He stated he was not aware of how long it had taken to start CPR. He said nobody had informed him there might be problems with staff response to Patient #3's cardiopulmonary arrest.</p> <p>During a follow-up interview with RN C on 2/24/12 beginning at 7:50 AM, he confirmed the delay in starting CPR and the delay in the arrival of emergency equipment. He stated he was not aware if changes had been made to the CPR procedure following the event on 9/24/11. He stated at present nobody was specifically assigned to bring the emergency cart to the scene.</p> <p>c. The LPN, who was on duty at the time of</p>	A 144			

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A 144	<p>Continued From page 10</p> <p>Patient #3's arrest, was interviewed on 2/24/12 beginning at 7:35 AM. She was asked about her responsibilities in a "Code Blue" situation. She stated "Code Blues" were called for multiple situations where a possible medical emergency could be present, such as seizures, falls with injury, fainting, and cardiopulmonary arrest. The LPN stated she was not sure whose responsibility it was to get the emergency cart. The LPN said she did not have a specific role in a code situation. She stated she was not sure if there was a policy which specified her role or not. The LPN said she did not know what the hospital's Code Blue policy called for. She stated she was not sure if she should announce the code over the Public Address system at night because it might upset other patients. She stated she thought the response to cardiopulmonary arrest should be more organized but they happened so rarely it was hard to be consistent.</p> <p>d. RN B, a Charge Nurse on duty on 2/23/12, was interviewed on 2/23/12 at 2:00 PM. When asked about her expectation for how a PT should handle a situation if he/she were to find a patient who was not breathing and did not have a pulse, she stated she expected the PT to get the RN and wait for guidance by the RN who would assess the patient. She would delegate responsibilities after she arrived at the scene. She did not indicate the PT should initiate CPR if there was a delay in getting the RN's attention. She stated she expected the PT to wait for the RN.</p> <p>e. PT D, a staff member on duty on 2/23/12, was interviewed on 2/23/12 at 1:55 PM. When asked how he would handle a situation if he found a patient who was not breathing and did not have a</p>	A 144			

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A 144	Continued From page 11 pulse, he stated he would check the code status of the patient, notify the charge nurse by use of a call light and would wait for the nurse to arrive to give direction. He would avoid yelling out because he would not want to alarm other patients. He would stay with the patient but would "wait for the RN to direct the code." Nursing staff were not consistent in their understanding of the "Code Blue" procedure at the hospital. A study published by the NIH in April 2002, titled "Characteristics and outcome among patients suffering from in hospital cardiac arrest in relation to the interval between collapse and start of CPR." was reviewed. It concluded, when CPR was started within the first minute after collapse, "...survival to discharge was twice that of patients in whom CPR was started later. These results highlight the importance of immediate CPR after in-hospital cardiac arrest." It took at least 3 minutes and 28 seconds to begin CPR on Patient #3. This placed him at significantly higher risk for death than if the CPR had been initiated within 1 minute. In addition, the hospital had not taken steps to analyze the CPR efforts for Patient #3, nor had they taken steps to improve response times for future events. This placed the health and safety of patients at risk of serious harm or death, should a similar event occur.	A 144			
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other	A 168			

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A 168	<p>Continued From page 12</p> <p>licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of records and hospital policy, it was determined the hospital failed to ensure seclusion was in accordance with the order of a physician for 1 of 3 restrained or secluded patients (#4) whose records were reviewed. This resulted in a patient being secluded without appropriate authorization. Findings include:</p> <p>A hospital policy, "Restraint," dated 12/00, stated restraints require the order of a physician and have a maximum duration of 4 hours for adults 18 years and older.</p> <p>Patient #4 was a 21 year old male who was admitted to the hospital on 7/28/11 for psychosis after being incarcerated. Physician orders for seclusion, related to Patient #4's aggressive and assaultive behavior, were present in Patient #4's record for the following dates and times:</p> <p>8/04/11 at 10:08 AM 8/04/11 at 4:35 PM (this was 6 hours and 27 minutes after the prior order, 2 hrs and 27 minutes more than the maximum duration of 4 hours allowed before a renewal order was required) 8/04/11 at 8:35 PM 8/05/11 at 12:30 AM 8/05/11 at 4:30 AM 8/05/11 at 8:20 AM</p>	A 168	<p>Patient Rights: Restraint or Seclusion A168 482.13(e)(5): The CNO and CEO reviewed the seclusion and restraint policy and reaffirmed that the policy requires an individual order for each seclusion and restraint episode and requires implementation of all CMS standards related to seclusion and restraints.</p> <p>The CNO reviewed and addressed the seclusion and restraint process to include the physician orders under the current policy. Physician's orders for seclusion and restraint use include length of time of use, release criteria and associated release criteria and documentation in accordance with the State law.</p> <p>The CNO provided direct face to face retraining to all licensed staff to review the hospital policy and CMS requirements that all seclusion and restraints must be in accordance with the physician's order. Retraining was provided on all revised forms (Attachment – C) approved through Quality Council, MEC and Board of Governors. Retraining was completed on March 28, 2012 to all licensed nursing staff.</p>	2/24/12	2/24/12	3/28/12

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A 168	<p>Continued From page 13</p> <p>8/05/11 at 3:20 PM (this was 7 hours between renewal orders, 3 hours more than the maximum duration of 4 hours allowed)</p> <p>Restraint flow sheets documented Patient #4 was in seclusion between 8/04/11 at 10:05 AM through 8/05/11 at 5:00 PM. Narrative documentation indicated Patient #4 continued to be secluded on 8/06/11. An RN's narrative, dated 8/06/11 at 8:15 AM, documented a nurse discussed with Patient #4 "because of his behavior the day prior, the door needed to remain locked for his safety." A psychiatric technician's progress note, dated 8/06/11 at 1:36 PM, stated Patient #4 remained in "Obs" and he was told to knock on window for any needs." A physician's progress note, dated 8/06/11 at 3:27 PM, stated Patient #4 was left behind locked doors and monitored on a one to one basis. He documented speaking with the CNO the day prior about the patient's status. The CNO indicated he had left documentation justifying the patient remaining behind locked doors given his level of aggression.</p> <p>There were not valid physician orders for seclusion during the following times when Patient #4 was secluded:</p> <p>8/04/11 2:08 PM until 4:35 PM 8/05/11 12:20 PM until 3:20 PM 8/06/11 for an undetermined period of time</p> <p>In addition to physician orders, RN documentation on a physician order sheet, dated 8/05/11 at 12:50 PM, documented "per nursing supervisor, pt [Patient #4] to remain in seclusion by orders of DON. Call into a physician who is</p>	A 168	<p>The Medical Director addressed the Seclusion/Restraint policy requirements for physicians during the monthly Peer Review Committee which occurred on March 14, 2012. The physician group discussed the maximum time frames for seclusion/restraint as well as re-assessments of patients requiring longer than 4 hour seclusion/restraint. The education also included release criteria and physician related documentation. The Medical Director addressed what specific requirements for nursing audits would be completed for all seclusion/restraint patients and that these audits and findings will be included in MEC agenda per performance improvement discussions.</p> <p>The Nurse Managers and/or Nursing supervisors now monitor all patients placed in seclusion or restraint to ensure that the use of seclusion and/or restraint is in accordance with the physician's order to include and MD order for seclusion and restraint; 1 hour LIP evaluation completed timely and release criteria.</p>	3/14/12	
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A 168	<p>Continued From page 14 discussing matter with administration."</p> <p>The CNO was interviewed on 2/22/12 at 11:20 AM. He explained Patient #4 was a danger to others and had already injured two staff members. He explained one staff member was hospitalized with a head injury as a result of Patient #4's assaultive behavior and had not been able to return to work. He described Patient #4 as violent, a risk to others, impulsive and compulsive and it was hard to predict when he would be violent. When asked about the documentation indicating he as the CNO had ordered continued seclusion, he stated it was his intention Patient #4 remain secluded in order to protect staff but that he was not qualified to give orders and he expected nursing staff to have obtained valid physician orders. He acknowledged physician orders were missing for some of the episodes of seclusion. He stated this had been discussed during a peer review process.</p> <p>Patient seclusion was not in accordance with an order of a physician.</p>	A 168	<p>Monitoring: The Nursing Managers and Nursing Supervisors are responsible for 100% review of all seclusion and restraints to ensure compliance with the physician's order and required documentation. A form was revised (Attachment – D) to review all seclusion and restraints and ensure that there is documentation that indicates reason for seclusion and/or restraint use; time placed in seclusion and/or restraint; release criteria identified; total time of seclusion and/or restrain; patient's behavior during seclusion and/or restraint; time of release and medication name, route, administration time and patient administration information. All data will be reported monthly to the Quality Council and Patient Safety Committee and to the MEC and Board of Governors quarterly. Audits will continue for 3 months and will decrease to periodic checking when compliance is achieved and sustained. Noncompliance with the Seclusion and Restraint policy will have immediate licensed staff peer review completed by the Nurse Managers and/or Nursing Supervisors. Trending of these outliers will be reported and addressed through Quality Council and at Unit Program Meetings.</p>		3/28/12

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A 168	Continued From page 14 discussing matter with administration." The CNO was interviewed on 2/22/12 at 11:20 AM. He explained Patient #4 was a danger to others and had already injured two staff members. He explained one staff member was hospitalized with a head injury as a result of Patient #4's assaultive behavior and had not been able to return to work. He described Patient #4 as violent, a risk to others, impulsive and compulsive and it was hard to predict when he would be violent. When asked about the documentation indicating he as the CNO had ordered continued seclusion, he stated it was his intention Patient #4 remain secluded in order to protect staff but that he was not qualified to give orders and he expected nursing staff to have obtained valid physician orders. He acknowledged physician orders were missing for some of the episodes of seclusion. He stated this had been discussed during a peer review process.	A 168			
A 396	Patient seclusion was not in accordance with an order of a physician. 482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure a nursing care plan was developed that addressed the nursing needs of 1 of 13 patients (#3) whose records were reviewed. This resulted in a lack of direction for nursing staff. Findings	A 396	A396 482.23(b)(4) The CNO, Nurse Managers, Nursing Supervisors and CEO met to review and revise the nursing care plan (Master Treatment Plan – MTP) process. The treatment planning process was reviewed and a form	3/12/12	

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A 396	Continued From page 16 The hospital did not develop a complete nursing care plan for Patient #3.	A 396	<p>Nursing Managers or designee are responsible for completing a daily audit of each patient record for their respective unit(s) to ensure that the nursing care plans (MTP) are updated and current.</p> <p>The CNO and/or designee now completes a random sample (30 open charts) monthly audit of nursing care plans (MTP) to identify any identified opportunities to improve and the associated re-education of nursing staff.</p> <p>The CNO and/or designee will review 100 percent of the audits completed (30) by the Nurse Managers / Supervisors in their respective units. Data will be submitted monthly to the Quality Council and to the MEC and Board of Govenors quarterly. Audits will continue for 3 months and will decrease to periodic checking when compliance is achieved and sustained.</p>		

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A 449	<p>The hospital did not develop a complete nursing care plan for Patient #3.</p> <p>482.24(c) CONTENT OF RECORD</p> <p>The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, policies and procedures, and staff interviews, it was determined the hospital failed to ensure that nursing and medical staff documented condition changes and responses to medications and services in a timely manner for 1 of 13 patients (Patient #3) whose records were reviewed. This resulted in a lack of clarity about a patient's changing condition, response to treatment, and the provided interventions. Findings include:</p> <p>Patient #3's medical record documented a 47 year old male who was admitted to the hospital on 9/17/11. He died on 9/24/11. His diagnoses included schizoaffective disorder, post-traumatic stress disorder, alcohol abuse, hypertension, possible pulmonary embolism, a fractured right arm, post-traumatic amputation of left leg below the knee, and sores on his stump. He was admitted for suicidal ideation and alcohol detoxification. Documentation in Patient #3's medical record was not timely as follows:</p> <p>1. On 9/27/11 at 2:23 PM, the family practice physician who cared for Patient #3 dictated a "PROGRESS NOTE". The first line of dictation</p>	A 449	<p>Content of Record A449 482.24(c):</p> <p>The CNO, Medical Director, CEO and PI Director met to review the documentation process that ensures that the patient's change in condition, response to treatment and interventions are documented by the medical staff and the nursing staff. The change in patient's status policy was reviewed.</p> <p>Medical Staff Specific Plan of Correction</p> <p>The Medical Director/Designee provided retraining to the medical staff on the required documentation on the daily progress notes indicating the patient's change in condition, responses to medications and treatment interventions. The Medical Director/Designee also completed a review of the requirements for consults per Medical Staff Rules and Regulations with the MEC participants which included the requirements for immediate documentation of the consult (hand-written/dictated) which included the following requirements:</p> <ul style="list-style-type: none"> • Reason for consult • Findings • Recommendations for Care • Follow-up needs <p>Medical Staff completed the above education on March 27, 2012.</p>		3/27/12

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NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 449	<p>Continued From page 17</p> <p>was, "This is a late entry dictated on 09/27/2011 as I was called away from the hospital on the morning I had seen the patient and had intended to dictate this note when I returned to see him in followup." The date of the visit was not include in the note. After reviewing the physician orders for consultation in Patient #3's record on 2/29/12 at 10:40 AM, the CNO informed surveyors that the visit for the progress note dictated on 9/27/11 at 2:23 PM took place on 9/23/11. However, the exact date of the visit was unclear as the progress note documented "I asked that he be allowed to wear a sling on his right forearm, to keep elbow flexed at 90 degrees and plan to follow up with him on September 23rd."</p> <p>The above referenced progress note included the following: "Had fractured his right arm and was getting inadequate pain relief." The plan documented by the physician included, "Start methadone 10 mg b.i.d. Discontinue Norco and use Oxycodone IR 5 mg four tabs q 6 p.r.n. breakthrough pain. Explained potential risks and side effects of long-acting analgesics such as methadone including sleepiness, constipation, nausea, vomiting, risk of profound sedation and respiratory depression resulting in death. It would take three to four days to achieve an adequate serum level to appreciate any analgesia and at that time would titrate off short-acting medications." As a result of late dictation, pertinent information related to the status and care of Patient #3 was unavailable to other physicians and medical staff.</p> <p>2. On 9/27/11 at 3:29 PM, the family practice physician documented a consultation note about Patient #3. The first line of documentation said,</p>	A 449	<p>Monitor:</p> <p>All data will be aggregated, analyzed and reported by the Director HIM to Peer Review Committee a subcommittee of the Medical Executive Committee as part of physician credentialing and ongoing performance improvement of the Medical Staff. The findings of the Peer Review will be addressed through MEC and Board of Governors quarterly. Audits will continue for 3 months and will decrease to periodic checking when compliance is achieved and sustained.</p> <p>Nursing staff Specific Plan of Correction</p> <p>The CNO reviewed the current patient assessment form (IMH Nsg Flow Sheet – Attachment - G) and determined re-education of licensed staff was required in order to meet the documentation requirements for change in patient condition identified by the deficiency. The IMG Nsg Flow sheet narrative section will be utilized in order to address specific changes in the patients' condition and the related licensed staff documentation of that change. The CNO provided retraining to the nursing staff on the revised policy and procedure (1000.9) related to assessment and documentation of the patient's change in condition, response to treatment and treatment interventions.</p>	<p>2/29/12</p> <p>3/30/12</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

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A 449	<p>Continued From page 18</p> <p>"This is a late entry as the chart was unavailable when I returned to round on the patient. This is dated September 23, 2011." The delay in dictation prevented other physicians and medical staff from being aware of information that may have been pertinent to the on-going care of Patient #3. An example of pertinent information was, "OBJECTIVE: Vitals are stable, but patient is quite drowsy, he has pinpoint pupils, answers questions appropriately with mild slurred speech." Another example was, "ASSESSMENT: Side effect of Methadone (over-sedation), and constipation, acute right forearm from a fracture, end stage degenerative joint disease, right elbow, ongoing pressure points left thumb."</p> <p>3. An "OVERFLOW NURSING NARRATIVE" note dated 9/24/11 at 6:47 AM included documentation by RN A, who stated, "Began CPR with Charge Nurse after Pt found unresponsive at 0645. Attached AED which advised no shock required. No pulse felt, no breathing observed, no response noted, continue CPR." There was no progress note found in Patient #3's record describing the events surrounding Patient #3's death completed by RN C, the Charge Nurse who directed resuscitation efforts.</p> <p>The CNO was interviewed on 2/29/12 at 10:40 AM. He reviewed Patient #3's record and stated he was unable to locate a nursing progress note describing the code blue and CPR completed by RN C who directed the code.</p> <p>A policy, "Clinical Services Documentation in Pt. Record," last revised on 3/09 documented as follows: "The RN will make an additional entry in</p>	A 449	<p>The Nurse Managers/Supervisors are responsible for forwarding all incident reports that indicate a change in patient's condition and requires a transfer to a medical facility. The Nurse Managers will review the documentation of all records in their respective units to ensure that patient's change in condition, response to medications and treatment interventions are documented. Non compliance will be addressed immediately with the respective staff and retraining will be provided.</p> <p>Monitor: All data will be aggregated, analyzed and reported by the CNO to the Quality Council Committee and MEC and Board of Governors quarterly. Audits will continue for 3 months and will decrease to periodic checking when compliance is achieved and sustained.</p>		

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A 449	Continued From page 19 the event of an unusual event or incident for both medical conditions and psychiatric changes. This note will include a description of the event, staff intervention, and patient response to the intervention." This was not done. The facility failed to ensure Patient #3's change in condition, response to drugs and services and provided interventions were thoroughly documented in a timely manner.	A 449			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDUGBD	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/29/2012
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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation of your hospital. The surveyors conducting the investigation were: Teresa Hamblin, RN, MS, HFS Gary Guiles, RN, HFS Rebecca Lara, RN, BA, HFS	B 000		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure a nursing care plan was developed that addressed the nursing needs of 1 of 13 patients (#3) whose records were reviewed. This resulted in a lack of direction for nursing staff. Findings include:	BB175	16.03.14.310.03 Patient Care Plans The CNO, Nursing Managers, Nursing Supervisors and CEO met to review and revise the nursing care plan (Master Treatment Plan- MTP) process. The treatment planning process was reviewed and a form (Flow sheet- Attachment E was created to assist the nursing staff on the units identify patient problems/ symptomology and interventions to add to the nursing care plan (MTP.) Nursing care plan (MTP) documentation forms were reviewed and revised to eliminate generic goals and interventions and better format for documenting nursing needs that provide direction for the nursing staff. The CNO provided retraining to all licensed nursing staff on the revised nursing care plan process and format which was completed on March 30, 2012. Training elements for the Nursing staff included development of individualized goals and interventions for each patient. Nursing care plans (MTP) and problem lists were revised to accommodate increased individualization with emphasis on updating the nursing care plan (MTP) as needed. This information was discussed during program development meetings held between March 19 and March 30, 2012. A specific staff reminder and review was also included in the facility's weekly information document (In The Loop) completed March 23 and March 30, 2012. (Attachment- F). Nursing Managers or designee are responsible for completing a daily audit of each patient record for their respective unit(s) to ensure that the nursing care plans (MTP) are updated and current. The CNO and/or designee now completes a random sample (30 open charts) monthly audit of nursing care plans (MTP) to identify any identified opportunities to improve and the associated reeducation of nursing staff. The CNO and/or designee will review 100 percent of the audits completed (30) by the Nurse Managers/Supervisors in their respective units. Data will be submitted monthly to the Quality Council and to the MEC and Board of Governors quarterly. Audits will continue for three months and will decrease to periodic checking when compliance is achieved and sustained.	3/12/12 3/14/12 3/30/12

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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VYSI11

If continuation sheet 1 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDUGBD	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/29/2012
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BB175	Continued From page 1	BB175			
	Refer to A396 as it relates to the lack of nursing care planning.				
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88)	BB283	16.03.14.360.12 Record Content The CNO, Medical Director, CEO and PI Director met to review the documentation process that ensures that the patient's change in condition, response to treatment and interventions are documented by the medical staff and the nursing staff. The change in patient's status policy was reviewed. Medical Staff The Medical Director/Designee provided retraining to the medical staff on the required documentation on the daily progress notes indicating the patient's change in condition, responses to medication and treatment interventions. The Medical Director/Designee also completed a review of the requirements for consults per Medical Staff Rules and Regulations with the MEC participants which included the requirements for immediate documentation of the consult (hand-written/dictated) which included the following requirements: Reason for consult Findings Recommendations for Care Follow-up needs Medical Staff completed the above education on March 27, 2012.	3/27/2012	

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FACILITY STANDARDS

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BB283	Continued From page 2 iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when	BB283	16.03.14.360.12 Record Content Continued: Monitor: All data will be aggregated, analyzed and reported by the Director of HIM to the Peer Review Committee a subcommittee of the Medical Executive Committee as part of physician credentialing and ongoing performance improvement of the Medical Staff. The findings of the Peer Review will be addressed through MEC and Board of Governors quarterly. Audits will continue for three months and will decrease to periodic checking when compliance is sustained. Nursing: The CNO reviewed the current patient assessment form (IMH Nsg. Flow Sheet-Attachment- G) and determined reeducation of licensed staff was required in order to meet the documentation requirements for change in patient condition identified by the deficiency. The IMH Nsg. Flow sheet narrative section located on the back of the form will be utilized in order to address specific changes in the patients' condition and the related licensed staff documentation of that change. The CNO provided retraining to the nursing staff on the revised policy and procedure (1000.9) related to assessment and documentation of the patient's change in condition, response to treatment and treatment interventions.	2/29/12	3/30/12

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BB283	Continued From page 3 applicable. (3-1-90) This Rule is not met as evidenced by: Based on review of medical records, policies and procedures, and staff interviews, it was determined the hospital failed to ensure that nursing and medical staff documented condition changes and responses to medications and services in a timely manner for 1 of 13 patients (#3) whose records were reviewed. This resulted in a lack of clarity about a patient's changing condition, response to treatment, and the provided interventions. Findings include: Refer to A449 as it relates to the lack of documentation for Patient #3.	BB283	16.03.14.360.12 Record Content Continued: The Nurse Managers/Supervisors are responsible for forwarding all incident reports for indicate a change in patient's condition and requires a transfer to a medical facility. The Nurse Managers will review the documentation of all records in their respective units to ensure that patient's change in condition, response to medications and treatment interventions are documented. Non compliance will be addressed immediately with the respective staff and retraining will be provided. Monitor: All data will be aggregated, analyzed and reported by the CNO to the Quality Council Committee and MEC and Board of Governors quarterly. Audits will continue for three months and will decrease to periodic checking when compliance is achieved and sustained.	

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HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 15, 2012

Brent Bryson, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bryson:

On **February 29, 2012**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005240

Allegation #1: A patient was inappropriately kept in seclusion.

Findings #1: An unannounced visit was made to the hospital on February 21 through February 29, 2012. During the complaint investigation, surveyors reviewed patient records, hospital policies, restraint logs, incident reports, and administrative documents. They interviewed staff and patients and observed selected videotapes of staff interactions with patients.

A hospital policy, "Restraint," dated 12/00, stated restraints require the order of a physician and have a maximum duration of 4 hours for adults 18 years and older.

One record documented a 21 year old male who was admitted to the hospital on 7/28/11 for psychosis after being incarcerated. Physician orders for seclusion, related to the patient's aggressive and assaultive behavior, were present in his record, as follows:

8/04/11 at 10:08 AM

8/04/11 at 4:35 PM (this was 6 hours and 27 minutes after the prior order, 2 hrs and 27 minutes more than the maximum duration of 4 hours allowed)

Brent Bryson, Administrator
March 15, 2012
Page 2 of 3

8/04/11 at 8:35 PM
8/05/11 at 12:30 AM
8/05/11 at 4:30 AM
8/05/11 at 8:20 AM
8/05/11 at 3:20 PM (this was 7 hours between renewal orders, 3 hours more than the maximum duration of 4 hours allowed)

Restraint flow sheets documented the patient was in seclusion between 8/04/11 at 10:05 AM through 8/05/11 at 5:00 PM. Narrative documentation indicated the patient continued to be secluded on 8/06/11.

An RN's narrative, dated 8/06/11 at 8:15 AM, documented a nurse told the patient that because of his behavior the day prior, the door needed to remain locked for his safety. A psychiatric technician's progress note, dated 8/06/11 at 1:36 PM, stated the patient remained in the observation room and was told to knock on the window if he needed anything. A physician's progress note, dated 8/06/11 at 3:27 PM, stated the patient was left behind locked doors and monitored on a one to one basis.

There were not valid physician orders for seclusion during the following times the patient was secluded:

8/04/11 2:08 PM until 4:35 PM
8/05/11 12:20 PM until 3:20 PM
8/06/11 for an undetermined period of time

The Director of Nursing was interviewed on 2/22/12 at 11:20 AM. He acknowledged physician orders were missing for some of the episodes of seclusion. He stated this had been discussed during a peer review process.

The hospital was cited at CFR 482.13(e)(5) for secluding a patient without valid physician orders.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: The facility is using restraint and seclusion for disciplinary purposes.

Findings #2: It could not be determined hospital staff secluded or restrained patients for disciplinary purposes. Documentation and interview indicated patients were secluded or restrained when patients' were perceived to be a risk to themselves or others.

One record documented a 21 year old male who was admitted to the hospital on 7/28/11 for

Brent Bryson, Administrator
March 15, 2012
Page 3 of 3

psychosis after being incarcerated. Physician orders for seclusion, related to the patient's aggressive and assaultive behavior, were present in his record.

The Director of Nursing was interviewed on 2/22/12 at 11:20 AM. He explained the patient was a danger to others and had already injured two staff members. One staff member was hospitalized with a head injury as a result of the patient's assaultive behavior and had not been able to return to work. He described the patient as violent, a risk to others, impulsive, and compulsive, and said it was hard to predict when he would be violent.

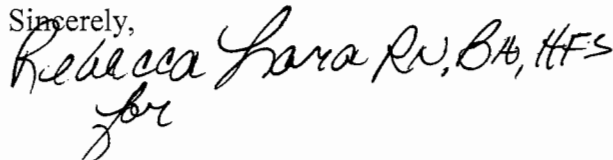
There was lack of evidence to determine staff secluded or restrained patients for disciplinary purposes.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Handwritten signature of Teresa Hamblin in cursive script.

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Handwritten signature of Sylvia Creswell in cursive script.

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm

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March 15, 2012

Brent Bryson, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bryson:

On **February 29, 2012**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005295

Allegation #1: A staff member in the Outpatient Department behaved in sexually inappropriate ways toward a patient.

Findings #1: An unannounced visit was made to the hospital on February 21 through February 29, 2012. During the complaint investigation, surveyors reviewed patient records, hospital policies, incident reports, personnel records and other administrative documents. They interviewed staff and patients.

Hospital records, dated 10/10/11, documented an allegation of sexual abuse by an outpatient Transportation Coordinator toward a patient involved in the "Partial Hospitalization" program. Hospital staff documented an investigation of the complaint, including interviews with the Transportation Coordinator, who was accused of inappropriate sexual conduct, and two patients who reported a sexual relationship with the Transportation Coordinator. The investigation included copies of inappropriate texts from the Transportation Coordinator to one of the patients. Hospital investigators concluded the staff member violated therapeutic boundaries. The Transportation Coordinator's employment was terminated on 10/11/11.

The personnel file of the Transportation Coordinator was reviewed. It included evidence of a criminal background check and training in therapeutic boundaries. The file documented the employee had sent text messages of a sexual nature to a patient and had inappropriately disclosed personal information to clients.

The Director of the Partial Hospitalization Program was interviewed on 2/23/12 at 8:05 AM. She stated, after the incident, the hospital instituted several measures to reduce the risk of similar events occurring. She stated the hospital hired a female driver who would be assigned to females who were assessed to be hypersexual around males. Drivers could no longer text clients or stop while transporting patients to or from the program. She stated they continued to require employees to do an annual review of therapeutic boundaries information. Drivers were expected to review and sign an agreement that communicated expectations.

The Director of the Partial Hospitalization Program provided a copy of a new document titled "Transport Safety Precautions." It included the following information:

- Transport clients to and from their place of residence only.
- Emergency stopping only.
- Hypersexual clients will be transported by same sex drivers to avoid potential concerns.
- Female transport coordinator has been implemented to ensure safety.
- Transport supervisor has been implemented to supervise transport coordinators to ensure safety and hold coordinators accountable for their actions.
- The transport approval form has been changed to include appropriate client expectations.
- Transport coordinators will discourage inappropriate conversations.
- Transport coordinators will maintain appropriate boundaries with clients (i.e. no texting permitted, refrain from discussing potentially volatile information).

The Director of the Partial Hospitalization Program also provided a copy of a new document titled "Transport coordinator Position Responsibilities and Expectations." It included the following information:

- Transport coordinators will maintain appropriate boundaries with clients
- Hypersexual clients will be transported by same sex drivers to avoid potential concerns
- Do not allow any inappropriate conversations during transport
- All client transports including taxi transports and any van stop of any kind that deviate away from normal route must first be approved by Transport Supervisor.

Transport Coordinators were required to sign acknowledgment of the form.

Although it appears allegations of sexual abuse were true, the hospital implemented measures to

Brent Bryson, Administrator
March 15, 2012
Page 3 of 3

reduce the risk of recurrence. Therefore no deficiencies are cited.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Rebecca Lara RN, BA, HFS
for

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm

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March 15, 2012

Brent Bryson, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bryson:

On **February 29, 2012**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005411

Allegation #1: Staff harassed patients through verbal ridicule and taunting.

Findings #1: An unannounced survey was conducted at the hospital from 2/21/12 through 2/29/12. Surveyors reviewed medical records, hospital video logs, hospital policies, incident reports, grievance logs and administrative documents. Surveyors also interviewed staff and patients and observed staff interactions with patients.

Several current patients were interviewed on various units in the hospital. They were unable to recall any incidents of patients being taunted or ridiculed by staff and stated patients were treated with respect.

One medical record reviewed documented a 43 year old female who was admitted to the Intensive Care Unit (ICU) unit of the hospital on 1/12/12 with a diagnosis of bipolar disorder, manic with psychotic features. An "OVERFLOW NURSING NARRATIVE" note, dated 1/19/12 at 6:00 PM, and completed by the Registered Nurse (RN), documented the patient's affect as labile with mood changes from angry to sad. The note stated the patient was easily agitated and was yelling at staff during the shift, while slamming doors and the phone. The note

also stated the patient said the staff humiliated her last night by gathering around her and singing "Old McDonald had a farm" while she was on the phone.

An "Interdisciplinary Treatment Note," dated 1/19/12 and untimed, completed by an RN stated the patient, "Alleged that ten staff members surrounded her yesterday while she was on the phone and the supervisor lead a song "Old McDonald had a farm" to mock her." The note also documented the patient did not want to take any antipsychotic medication because she reported being "a mess when she was on it."

The "DISCHARGE SUMMARY," dictated by the physician on 1/27/12 at 5:21 PM, documented the patient was admitted due to paranoia and delusional thinking. The discharge summary also stated the patient "at one point thought staff gathered around her, about 10 of them, and mocked her by singing, "Old MacDonald had a farm with a quack here and a quack there. This was apparently, a hallucination, although the patient never thought she had hallucinations."

On 2/22/12 and 2/27/12, surveyors reviewed video tapes of interactions between staff and patients that took place on the ICU unit, in the hall where the patient phone was located. The tapes also included a view of the nurses' station. ICU video tapes for the evenings of 1/14/12, 1/15/12, 1/16/12, 1/17/12, 1/18/12 and 1/19/12 were reviewed. There were no incidents observed of a group of staff gathered around a patient. There were also no observations of a group of staff singing to or about a patient.

Various staff members on the ICU unit were interviewed, including nurses, social workers, and psychiatric technicians. All staff stated they did not recall having ever witnessed another staff member harassing a patient.

Due to a lack of sufficient evidence, the allegation of patient harassment could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Contaminated clothing/linens and garbage were left in an area located near patient service and food storage areas, and could have been an infection control hazard.

Finding #2: An unannounced survey was conducted at the hospital from 2/21/12 through 2/29/12. Surveyors reviewed medical records, hospital video logs, hospital policies, incident reports, grievance logs and administrative documents. Surveyors also interviewed staff and patients and observed staff interactions with patients.

Surveyors visited the ICU on various days during the survey. The cart for soiled linens was

always located in a room designated for contaminated linens, behind a locked door. There was a garbage can located near the nurses' station, but it was clean and not located near a food storage area.

On 2/22/12 and 2/27/12, surveyors reviewed video tapes of the ICU patient hallway and nurses' station. ICU video tapes for the evening shifts of 1/14/12, 1/15/12, 1/16/12, 1/17/12, 1/18/12 and 1/19/12 were reviewed. On 1/16/12, staff on the video was observed wheeling the dirty linen cart out of the dirty linen room and collecting soiled linens from various rooms on the unit. The cart was then wheeled off the unit. There were no visible incidents of garbage or contaminated clothing and linens in the food storage or patient service areas.

Various ICU staff were interviewed throughout the survey. Staff stated the practice was to collect the linens and place them in a cart that was stored in a locked room until the linens could be removed from the unit and sent for cleaning.

No evidence could be found that contaminated linens and garbage were left near food storage and patient service areas. Therefore, the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient was unnecessarily kept on a more restrictive unit and denied a request to move to a unit that was less restrictive.

Finding #3: An unannounced survey was conducted at the hospital from 2/21/12 through 2/29/12. Surveyors reviewed medical records, hospital video logs, hospital policies, incident reports, grievance logs and administrative documents. Surveyors also interviewed staff and patients and observed staff interactions with patients.

One medical record reviewed documented a 43 year old female who was admitted to the ICU of the hospital on 1/12/12 with a diagnosis of bipolar disorder, manic with psychotic features. Though the patient was admitted on a voluntary basis, on 1/16/12 at 4:00 PM, a physician's order was written that stated, "Place pt on mental health hold."

An "OVERFLOW NURSING NARRATIVE" note, dated 1/19/12 at 6:00 PM, and completed by the Registered Nurse (RN), documented the patient's affect as labile with mood changes from angry to sad. The note also stated the patient was easily agitated and was yelling at staff during the shift, while slamming doors and the phone. The note also stated the patient said the staff humiliated her last night by gathering around her and singing "Old McDonald had a farm" while she was on the phone.

A social worker on the ICU was interviewed on 2/22/12 at 11:05 AM. She stated the patient was exhibiting delusional behavior and described the patient as manic and hypervocal. She said the patient was angry about being placed on a legal hold, but did not recall that the patient asked to be transferred to another unit.

The Director of Performance Improvement and Risk Management was interviewed on 2/22/12 at 10:20 AM. She stated the most high risk patients and patients on any type of "legal hold or commitment process" were admitted to ICU. The Director said the ICU treatment team considered requests from patients to move to other less restrictive units, but in order to be transferred, patients "could not be a threat to self or others and symptoms must be under control."

No evidence could be found that a request to move to another unit had been denied or that the placement of patients on the ICU were inconsistent with the standard processes of the hospital. Therefore, the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Personal property was stolen from a patient.

Findings #4: An unannounced survey was conducted at the hospital from 2/21/12 through 2/29/12. Surveyors reviewed medical records, hospital video logs, hospital policies, incident reports, grievance logs and administrative documents. Surveyors also interviewed staff and patients and observed staff interactions with patients.

One medical record reviewed documented a 43 year old female who was admitted to the ICU of the hospital on 1/12/12 with a diagnosis of bipolar disorder, manic with psychotic features. At the time of admission, a list of the patient's personal belongings was documented. The list included several articles of clothing. No documentation could be found in the record indicating that any of the patient's personal belongings were reported as stolen during the admission.

The grievance log was reviewed on 2/21/12. Several written grievances by patients about stolen personal property were reviewed. There was documentation indicating all grievances were investigated, and in some instances, the hospital reimbursed the patients estimated cost of stolen property.

Current ICU patients were interviewed. They were unable to recall any incidents of stolen belongings during their hospitalization.

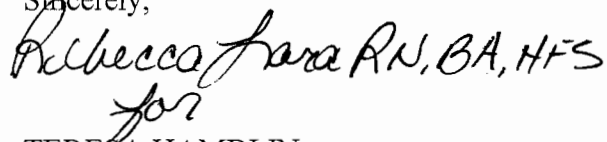
Due to a lack of sufficient evidence, the allegation of stolen property could not be substantiated.

Brent Bryson, Administrator
March 15, 2012
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Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Handwritten signature of Rebecca Lara in cursive script.

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Handwritten signature of Sylvia Creswell in cursive script.

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm

COPY



IDAHO DEPARTMENT OF
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March 15, 2012

Brent Bryson, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bryson:

On **February 29, 2012**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005419

Allegation #1: Medical staff were negligent in caring for a patient culminating in his death.

Findings #1: An unannounced visit was made to the hospital on 02/21/12 to 02/29/12. Staff and patients were interviewed. Surveillance video was viewed. Medical records of 13 patients were reviewed. Hospital policies, meeting minutes, and quality improvement documents were reviewed. An autopsy report and police report were reviewed.

One patient's medical record documented a 47 year old male who was admitted to the hospital on 9/17/11. He died on 9/24/11. His diagnoses included schizoaffective disorder, post-traumatic stress disorder, alcohol abuse, hypertension, possible pulmonary embolism, a fractured right arm, post-traumatic amputation of left leg below the knee, and sores on his stump. He was admitted for suicidal ideation and alcohol detoxification. The Discharge Summary by the attending physician, dated 10/07/11, stated the patient was found unresponsive at 6:45 AM on 9/24/11 and CPR was initiated. The Discharge Summary stated the patient was pronounced dead by paramedics at 7:02 AM on 9/24/11.

An autopsy report, signed on 12/14/11, listed findings of "Multidrug overdose." Under

"COMMENT:" the autopsy report stated "The lungs were heavy with pulmonary edema present and microscopic examination showed a mild acute pneumonia. The postmortem toxicology report performed on femoral vein blood showed markedly elevated concentrations of Olanzapine (Zyprexa) and Citalopram (Celexa) with therapeutic concentrations of Oxycodone, Vistaril, and the benzodiazepines Nordiazepam and Demoxepam (metabolites of Librium).... Conversations with a forensic toxicologist indicate that the combined effects of these drugs would result in death."

The patient's admitting orders on 9/17/11 included Zyprexa 10 milligrams (mg) at bedtime for psychosis and Celexa 20 mg daily for depression. His "PSYCHIATRIC EVALUATION," dated 9/18/11, stated his medications at the time of admission included Lysinopril 20 mg daily for blood pressure, Valium 10 mg at bedtime for anxiety, Warfarin daily as a blood thinner, Norco 7.5/325 every 4 hours as needed for pain, Zyprexa 30 mg daily for psychosis, and Celexa 40 mg daily for depression. The discrepancy between the dosages of Zyprexa and Celexa from those on admission were not explained. The evaluation stated the patient would be started on a detoxification protocol with Librium 50 mg every 2 hours as needed for alcohol withdrawal. The evaluation also stated the patient's Celexa was being increased to 60 mg per day and his Zyprexa was being increased to 45 mg per day. He was placed on 15 minute safety checks.

"Medication Administration Records" (MARs) documented the patient received no Librium on 9/17/11 but did receive Librium at 2:05 AM and 6:40 PM on 9/18/11. He did not receive Librium on 9/19/11. The Valium was discontinued on 9/20/11. He received Librium 3 times on 9/20/11 but he did not receive Librium after that.

The patient received Norco twice on 9/18/11 and 5 times on 9/19/11. On 9/20/11, he received Norco at 7:15 AM and 12:00 noon and then the dosage was increased to 10/325, which he received at 4:10 PM. He received Norco once on 9/21/11 and then it was discontinued. On 9/21/11, the pain medications Methadone 10 mg and Oxycodone 20 mg were ordered 2 times a day and every 6 hours as needed, respectively. The Methadone was given 2 times and the Oxycodone was given 2 times on 9/21/11. The Methadone was given 2 times and the Oxycodone was given 2 times on 9/22/11. On 9/23/11, he received Vistaril 50 mg for anxiety at 12:15 AM. On 9/23/11, the Methadone was given in the morning but was then held in the evening. The Oxycodone was decreased to 5 mg on 9/23/11 and he received that drug at 1:30 PM and 6:10 PM.

The patient received Zyprexa 10 mg on 9/17/11. He received Celexa 20 mg and Zyprexa 45 mg on 9/18/11. He received Zyprexa 45 mg on 9/19/11 but no Celexa was administered due to a trip to the emergency room. On 9/20/11, he received Celexa 60 mg and Zyprexa 45 mg. On 9/21/11, he received Celexa 60 mg and Zyprexa 40 mg. On 9/22/11, he received Celexa 60 mg and Zyprexa 35 mg. On 9/23/11, the Celexa was held and he received Zyprexa 35 mg. Clozapine

12.5 mg, another antipsychotic medication, was given on 9/22/11 and 9/23/11.

The patient was admitted to the hospital on 9/17/11, after being evaluated at a local emergency room. A history and physical examination (H&P) by a Nurse Practitioner was performed on 9/18/11 at 11:58 AM. The H&P was cosigned by a physician. He was also seen by a psychiatrist at 3:54 PM that day and a Psychiatric Evaluation was done. At 12:02 AM on 9/19/11, the patient was transferred to a local emergency room for evaluation after throwing up blood. The findings were benign and he returned to the hospital around 5:00 AM on 9/19/11. His care was transferred to another psychiatrist on 9/19/11. This physician saw him at 12:36 PM and noted he had some chest pain with inhalation, he appeared sedated, and his speech was "a little thickened" although he had a normal rate and volume. The psychiatrist also saw the patient on 9/20/11 and wrote he seemed anxious and depressed. The psychiatrist stated his speech and gait were normal. The psychiatrist wrote an order for an electrocardiogram on 9/20/11. The psychiatrist documented the electrocardiogram was ordered because the patient was taking 60 mg of Celexa. The electrocardiogram showed the patient was in a normal sinus rhythm.

The patient was seen by a family practice physician for medical issues on the morning of 9/21/11. The physician wrote he had no neurological deficits. The visit focused on pain control and the patient was started on Methadone and Oxycodone. The physician wrote he explained the potential risks of the pain medications to the patient up to and including death from respiratory depression. He wrote he was deferring a consult by an orthopedist for his fractured arm. The physician also ordered a sling for the patient's arm. However, this was not supplied due to the patient's risk for suicide.

The psychiatrist saw the patient on 9/21/11 and wrote the patient was "...having persistent hallucinations despite the fact that he is getting 45 mg of Zyprexa which is more than twice the maximum recommended dose...I will decrease the Zyprexa a bit to 40 mg and start him at a low dose of Clonazepam..." The psychiatrist wrote the other physician had changed the patient's pain medication to Methadone and Oxycodone. The psychiatrist also noted an electrocardiogram had been obtained and was within normal limits. The psychiatrist saw the patient on 9/22/11 and wrote the patient's attention and concentration were intact. He wrote the Clozapine had not been started because they were awaiting laboratory tests. The Zyprexa was decreased to 35 mg.

The patient was seen by the family practice physician on 9/23/11 who wrote orders at 3:30 PM. The progress note was dated 9/27/11 and did not state the time the patient was examined. The first line of documentation said, "This is a late entry as the chart was unavailable when I returned to round on the patient. This is dated September 23, 2011." The physician further documented "Vitals are stable, but patient is quite drowsy, he has pinpoint pupils, answers questions appropriately with mild slurred speech." and "ASSESSMENT: Side effect of Methadone (over-sedation), and constipation ..." The physician stated the patient's lungs were clear and his

heart was regular without a murmur. The physician ordered the Methadone held and the Oxycodone decreased on 9/23/11. The physician's note, on 9/23/11, did not mention the electrocardiogram but the physician did sign the test on 9/23/11 and write he had discussed it with the patient.

The psychiatrist saw the patient on 9/23/11 at 6:33 PM and wrote the patient "...was oriented to person, place, time, and situation and attention and concentration were intact...Speech had a normal rate and volume...and there is no deficit in his gait and station..." The psychiatrist noted the Methadone and Oxycodone changes due to the patient's earlier slurred speech. This was the last documentation of physician contact with the patient.

The attending psychiatrist was interviewed on 2/23/12 beginning at 11:05 AM. He stated he recognized the patient was on large doses of Zyprexa and Celexa and was decreasing the dosages. He stated he had ordered an electrocardiogram because high doses of Celexa could cause problems with heart rhythm but this came back normal. He stated the patient had no signs of pneumonia when he was seen on 9/23/11. He stated the patient was not responding well to Zyprexa so it was being changed over to Clozapine. He stated he decided to taper the Zyprexa dose instead of stopping it because the patient was still hallucinating. He said he had waited to start the Clozapine until laboratory test results were back because Clozapine could affect blood counts. He stated when he saw the patient on the evening of 9/23/11, the patient's speech was normal and he did not appear sedated. He stated there was nothing about the patient's condition that alarmed him.

The RN on the day shift on 9/23/11 documented the patient was "sedated." This assessment was not timed. She also documented the patient was cooperative with slight anxiety, that he attended groups, and he was pale and slightly diaphoretic (sweaty). The evening shift RN documented on 9/23/11 at 7:50 PM that the patient "Speaks very slowly & eyes do not also track well...(###) saw pt & will wean pt off Celexa & begin Cymbalta."

The evening shift RN, who was on duty on 9/23/11, was interviewed on 2/29/12 beginning at 10:30 AM. She stated she remembered the patient. She stated he was oriented and spoke intelligently. She stated the reference to his eyes not tracking well referred to a lack of eye contact. She stated he did not have neurological symptoms and his speech was not slurred. She said he just talked like he was depressed.

The night shift charge nurse who was on duty the early morning of 9/24/11, was interviewed on 2/23/12 beginning at 7:45 AM. He stated the patient slept all night and he did not notice anything unusual about the patient before he died.

A "NIGHT SHIFT REASSESSMENT" by the charge nurse at 5:35 AM on 9/24/11, checked the

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patient's respirations were within normal limits. No narrative nursing notes were documented.

Physicians documented daily visits. The patient was monitored by a psychiatrist and a family practice physician. They wrote orders in response to the patient's changing condition. An electrocardiogram was obtained to rule out complications. The psychiatrist recognized the Zyprexa and Celexa dosages were high and had reduced the dosages prior to the expiration of the patient.

Following the death, the medical staff implemented a "Polypharmacy" policy in October 2011 and February 2012, which included limits on certain types of medications and specific dosages on some medications. The policy requires, when a physician exceeds these parameters, the pharmacist will flag the medical record and the physician must document justification for the medications. If the physician fails to justify the medications, the case is referred to the Pharmacy & Therapeutics Committee for further action.

The progress notes by the family practice physician for 9/21/11 and 9/23/11 were not dictated until 9/27/11, 3 days after the above patient's death. This prevented other staff from incorporating those findings into planning for the patient's care. A deficiency was cited at 42 CFR Part 482.24(c) for the physician's failure to provide progress notes in a timely manner.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Nursing staff failed to monitor a patient's medical condition prior to his death.

Findings #2: An unannounced visit was made to the hospital on 2/21/12-2/29/12. Staff and patients were interviewed. Surveillance video was viewed. Medical records of 13 patients were reviewed. Hospital policies, meeting minutes, and quality improvement documents were reviewed. An autopsy report and police report were reviewed.

One patient's medical record documented a 47 year old male who was admitted to the hospital on 9/17/11. He died on 9/24/11. His diagnoses included schizoaffective disorder, post-traumatic stress disorder, alcohol abuse, hypertension, possible pulmonary embolism, a fractured right arm, post-traumatic amputation of left leg below the knee, and sores on his stump. He was admitted for suicidal ideation and alcohol detoxification. The Discharge Summary by the attending physician, dated 10/07/11, stated the patient was found unresponsive at 6:45 AM on 9/24/11 and CPR was initiated. The patient was pronounced dead by paramedics at 7:02 AM on 9/24/11.

The Ada County Coroner's "INVESTIGATION REPORT," closed on 1/03/12, stated, under the heading "DEATH," that the patient died at 6:16 AM on 9/24/11. However, the "DEATH EVENT DATA" column stated the "INCIDENT" occurred at 5:00 AM. The discrepancy was not

explained. The cause of death was listed as "Multidrug overdose."

The police report, approved on 10/08/11, stated the patient's "Unattended Death" occurred on 9/24/11 between 6:15 AM and 6:45 AM.

The patient's medical record documented he was admitted to the hospital at approximately 9:00 PM on 9/17/11. A protocol for alcohol withdrawal was ordered on admission. The protocol called for vital signs to be taken every 4 hours for 96 hours. Vital signs were documented every 4 hours for the first 96 hours. No specific orders for vital signs were written after that. Vital signs were documented once on 9/22/11. Once per day was the standard frequency for vital signs at the hospital unless otherwise ordered. Vital signs were documented at 9:30 AM on 9/23/11. The patient's blood pressure was high at 160/102 at that time. His pulse rate was 120. The corresponding "IMH NURSING FLOW SHEET," not timed, stated the physician was notified of the elevated pulse and blood pressure. The note stated the patient was given blood pressure medication and his blood pressure declined to 150/95 with a pulse of 120. The family practice physician, who monitored the patient's medical condition, saw him and wrote orders at 3:30 PM on 9/23/11. The physician progress note, which was not written until 9/27/11, stated the patient's vital signs were "stable." The progress note stated the patient was "quite drowsy" and had "mild slurred speech." Vital signs documented at 4:16 PM on 9/23/11, included a blood pressure of 112/63 and a pulse of 111. These were similar to the patient's usual vital signs. No other vital signs were documented.

The psychiatrist saw the patient on 9/23/11 at 6:33 PM and wrote the patient "...was oriented to person, place, time, and situation and attention and concentration were intact...Speech had a normal rate and volume...and there is no deficits in his gait and station..." The psychiatrist noted the Methadone and Oxycodone changes due to the patient's earlier slurred speech. This was the last documentation of physician contact with the patient.

The evening shift RN documented on 9/23/11 at 7:50 PM that the patient "Speaks very slowly & eyes do not also track well..."

The evening shift RN, who was on duty on 9/23/11, was interviewed on 2/29/12 beginning at 10:30 AM. She stated she remembered the patient. She stated he was oriented and spoke intelligently. She stated the reference to his eyes not tracking well referred to a lack of eye contact. She stated he did not have neurological symptoms and his speech was not slurred. She said he just talked like he was depressed.

The night shift charge nurse who was on duty the early morning of 9/24/11, was interviewed on 2/23/12 beginning at 7:45 AM. He stated the patient slept all night and he did not notice anything unusual about the patient before he died.

A "NIGHT SHIFT REASSESSMENT" by the charge nurse at 5:35 AM on 9/24/11, checked the patient's respirations were within normal limits. No narrative nursing notes were documented.

"PATIENT OBSERVATION RECORDS" documented staff visually observed the patient every 15 minutes during his stay including the night of 9/23/11 and the early morning of 9/24/11 through 6:45 AM.

A review of surveillance video from 6:00 AM through 7:30 AM on 9/24/11 showed the psychiatric technician entered the patient's room to check on patients at 6:02 AM, 6:18 AM, 6:31 AM and 6:43 AM on 9/24/11.

The psychiatric technician from the video was interviewed on 2/23/11 beginning at 2:32 PM. He stated he had worked at the hospital for over 2 years and he was a registered nursing student. He stated he made 15 minute checks on the night and morning of 9/23/11 and 9/24/11. He stated the hospital policy was to observe 3 breaths during the checks. He stated he carried a small flashlight in case it was difficult to see. He stated the patient was breathing when he made his check at 6:31 AM.

Monitoring of patients' conditions by nursing staff was documented in all 13 records reviewed.

Nursing staff monitored the patient who died. Two physicians saw the patient on the day prior to his death and neither ordered increased monitoring. Nurses on the evening and night shifts stated the patient did not exhibit unusual symptoms. The 15 minute checks were done.

The response by nursing staff when the patient was discovered in cardiopulmonary arrest was inadequate. Video review and staff interview showed that cardiopulmonary resuscitation was not initiated for at least 3 minutes and 28 seconds after it was identified that the patient was in cardiopulmonary arrest. In addition, it took 7 minutes and 12 seconds for nursing staff to bring emergency equipment to the scene. The equipment was stored approximately 50 feet away from the scene. On 2/24/12, it was determined that patients were at significantly increased risk for serious harm or death in a situation of cardiopulmonary arrest. A deficiency was cited at 42 CFR Part 482.13 for the failure of the hospital to provide care in a safe setting. The hospital submitted an immediate plan of correction and revised its cardiopulmonary resuscitation procedure that same day. The hospital began educating staff about the new procedure at 4:15 PM on 2/24/12. A follow up visit was conducted on 2/27/12 to ensure the plan of correction had been implemented.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The pharmacy did not monitor medications dispensed to a patient who died of a

Brent Bryson, Administrator

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drug overdose.

Findings #3: An unannounced visit was made to the hospital on 2/21/12-2/29/12. Staff and patients were interviewed. Surveillance video was viewed. Medical records of 13 patients were reviewed. Hospital policies, meeting minutes, and quality improvement documents were reviewed. An autopsy report and police report were reviewed.

The pharmacy service was observed and reviewed with the Pharmacy Director on 2/22/12 beginning at 2:20 PM. The pharmacy was staffed by the pharmacist and 3 pharmacy technicians at the time. This staffing was typical for the time and date. When medication orders were written by a physician, a direct copy of the order was reviewed by the pharmacist. The pharmacy technician entered the orders into the computerized Medication Administration Record. The computer automatically checked for drug interactions and allergies and notified staff of any problems. The pharmacy technician filled the orders. The orders and medications were checked by the pharmacist prior to transporting the medications to the floor. The initials of the pharmacist and the technician were garnered before transport. Medications that could potentially cause problems, such as look alike/sound alike medications and medications whose dosage required a pill to be broken in half, were labeled as such.

Two medication passes were observed on different units. On the units, patients were positively identified and medications were checked against the Medication Administration Record at the time of administration. Medications were accurately administered.

The hospital had an aggressive system to identify and review medication errors. All medication errors were reviewed by the pharmacist. The findings were presented to the Medical Staff.

An autopsy report identified one patient who died on 9/24/11. The cause of death was listed as multi-drug overdose. Following the event, the pharmacist had gathered all of the patient's medications and sequestered them. The medications had been correctly dispensed.

The pharmacy used a database called factsandcomparisons.com to identify drug interactions. The patient was prescribed Citalopram 60 mg, which was a high dose. At the time of the death, the pharmacist stated he queried the database and the dosage of Citalopram was not identified as a problem. He queried the database again in December 2011, when the autopsy findings were released. At that time, the database identified potential cardiac arrhythmia with high doses of Citalopram. Also, since the death, the package insert for Citalopram was changed to reflect potential cardiac problems.

It was also noted that the above patient was prescribed Clozapine during his stay. This medication can affect blood counts. The pharmacy held the medication for 2 days awaiting the

results of blood tests, before dispensing the medication.

The hospital's pharmacy had systems in place to accurately dispense medications and to prevent adverse drug reactions.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Nursing staff did not develop nursing care plans to meet patient needs.

Findings #4: An unannounced visit was made to the hospital on 2/21/12-2/29/12. Staff and patients were interviewed. Surveillance video was viewed. Medical records of 13 patients were reviewed. Hospital policies, meeting minutes, and quality improvement documents were reviewed. An autopsy report and police report were reviewed.

One patient's medical record documented a 47 year old male who was admitted to the hospital on 9/17/11. He died on 9/24/11. His diagnoses included schizoaffective disorder, post-traumatic stress disorder, alcohol abuse, hypertension, possible pulmonary embolism, a fractured right arm, post-traumatic amputation of left leg below the knee, and sores on his stump. He was admitted for suicidal ideation and alcohol detoxification.

The patient's "HISTORY AND PHYSICAL," dictated by the Nurse Practitioner on 9/18/11 at 11:58 AM, stated he fractured his right arm about a week prior to admission. The H&P stated the arm was in a cast. The H&P stated Patient #3's right arm was "very swollen" and "causes him a great deal of pain..." The H&P also stated Patient #3's prostheses was rubbing on the stump on his left leg causing a "shear abrasion." The H&P stated the NP was ordering Bacitracin ointment to help heal the abrasion.

The patient's nursing care plan was incorporated into the "MASTER TREATMENT PLAN." Neither the "TREATMENT PLAN INITIAL MTP STAFFING," dated 9/17/11 nor the "MASTER TREATMENT PLAN," dated 9/20/11, included the arm fracture or stump abrasions in the plan. Subsequently, daily nursing notes from 9/18/11 through 9/24/11 did not document the condition of the arm or the stump wounds.

The Director of Performance Improvement/Risk Management was interviewed on 3/6/12 at 4:00 PM. She confirmed the treatment plans did not include direction to staff regarding care of the patient's fractured arm and stump wounds.

The other 12 medical records contained nursing care plans that addressed their medical and nursing diagnoses.

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The lack of nursing care planning for the above patient prevented a consistent approach to minimizing pain and complications from the fractured arm and the skin breakdown. This caused increased arm pain which required additional pain medication. The allegation was substantiated and a deficiency was cited at 42 CFR Part 482.23(b,4) for incomplete nursing care plans.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,
for

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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March 15, 2012

Brent Bryson, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bryson:

On **February 29, 2012**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005423

Allegation 1: Staff abused a patient by responding to a physical altercation by shoving a patient into a room and across a bed.

Findings #1: An unannounced visit was made to the hospital on February 21 through February 29, 2012. During the complaint investigation, surveyors reviewed patient records, hospital policies, restraint logs, incident reports, and administrative documents. They interviewed staff and patients and observed selected videotapes of staff interactions with patients.

Several current patients were interviewed from various units of the hospital. They stated they felt staff treated them with respect. Incident reports did not document any similar incidents of staff pushing patients.

One record documented an 18 year old female who was admitted to the hospital on 2/05/12 with a diagnosis of bipolar affective disorder, manic with psychotic features. An incident with the patient and staff that occurred on 2/14/12 was captured on videotape. The surveyor viewed the videotape in coordination with the Risk Manager. The patient was observed in the video to raise her knee to the groin of a male RN, who reacted by pushing the patient into the seclusion room. The patient rolled over the bed and fell. The male RN then retreated, allowing other staff members to assume care of the patient.

On 2/22/12 at 1:45 PM, an interview was conducted with the RN who supervised the male RN who

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pushed the patient. She stated the patient had kneed the male RN in the groin, causing him pain. She stated the male RN should have stepped away after being kneed and allowed other staff members to deal with the patient. She stated after pushing the patient, the male RN who had been kneed retreated from the restraint episode and contacted a supervisor to report the incident. She stated the patient had no apparent injuries. In response to the incident, the male RN who pushed the patient was given a "mental health day" the following day to stay home and was told he could not participate in hands-on restraints until he had completed refresher training on restraints and therapeutic boundaries and had attended counseling with an EAP (Employee Assistance Program) counselor.


The male RN who pushed the patient was interviewed on 3/23/12 at 3:30 PM. He described the incident, stating the patient "kicked" him in the groin and he "reacted instinctively" to push her away from him because he was in pain. She ended up on the floor. He assisted her up to the bed after she fell and asked for other staff to take over. He stated it was not his intention to hurt the patient, he just reacted from being in pain, and wished he would have stepped back immediately and let others take over. He stated he had scheduled a counseling session and had viewed some of the mandated refresher training and intended to complete all of the required training as it became available. He stated he would not be participating in hands on restraints until he had been approved to do so.


The male RN's employee file was reviewed. There was evidence he had completed training in restraint education and therapeutic boundaries prior to the incident. He had also had a criminal background check. There was also evidence of disciplinary action that resulted from the incident.

The event was not the result of a deficient facility practice and the facility responded promptly and appropriately to the event. Therefore, no deficiencies were cited in relation to the event.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care


SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm